Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005040	A. BUILDING: _____ B. WING _____	10/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICE	1850 STATE ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Date of survey: 10-2-13 Facility number: 005040 Complaint number: IN00131534 Unsubstantiated; lack of sufficient evidence Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Floyd Memorial Hospital is in compliance with 410 IAC 15-1.5-1, Dietary Services, 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.5-5, Medical Staff, Hospital Licensure Rules. QA: claughlin 10/08/13	S 000		